Tuesday May 17, 2016 **HILTON HEALTH CARE, P.C.** **Acct#:** [redacted]
David Guest **DOB:** [redacted]/1997 **Sex:** M **Age:** 18 years

Subjective
CC: Patient presents with anxiety.
HPI: Patient presents with anxiety. Condition has been well controlled since last visit. Taking medication as prescribed. No side effects noted. No precipitating event. Aggravated by going to public places and relationship discord. Alleviated by exercise. Reports anxiety. Reports concentration is poor. Denies fearfulness. Reports heart racing. Reports the need to withdraw. Reports restlessness. Reports shaking. Denies suicidal thoughts. Reports tremors. Has sx persistently. Reports associated anxiety and panic attacks, but denies associated hyperventilation, nervousness, palpitations and excessive worry. Pt reports feelings of anxiety since middle school. Pt denies any suicidal toughts but sometimes feels he wishes he did not have to deal with the anxiety. because of issues with parents, pt has moved out and is living with GF or older brother or Aunt/Uncle.
ROS:
Const: Denies fatigue, loss of appetite, sweats, weight gain and weight loss. General health stated as good.
CV: Denies chest tightness, chest pain and palpitations.
Resp: Denies cough, SOB and wheezing.
GI: Denies abdominal pain, change in bowel habits, heartburn, nausea and vomiting.
Neuro: Denies dizziness, headache and memory lapses.
Psych: Reports anxiety, but denies depression, suicide attempts and suicidal thoughts.

Current Meds: Adderall 10 mg
Allergies: NKDA

Objective
Wt: 160lb **Wt Prior:** 160lb as of 02/12/16 **Wt Dif:** 0lb **Ht:** 69.5" 5'9.50" **BMI:** 23.3 **BMI%:** 65th
Pulse: 75 **BP:** 114/72 **Ht%:** 51st **Wt%:** 65th

Exam:
Const: Appears healthy and well developed. Weighs within the normal range. No signs of acute distress present.
Neck: Symmetric and supple on inspection. Palpation reveals no swelling or tenderness. Thyroid exhibits no nodules or thyromegaly.
Resp: Respirations are regular. No wheezing. Auscultate good airflow. Lungs are clear bilaterally.
CV: Rate is regular. Rhythm is regular. S1 is normal. S2 is normal. No heart murmur appreciated. **Extremities:** No clubbing, cyanosis or edema.
Abdomen: Bowel sounds normoactive. Abdomen is nontender. Abdominal wall is soft. No palpable hepatosplenomegaly.
Lymph: No visible or palpable cervical lymphadenopathy.
Neuro: Reflexes: DTR's are 2+ bilaterally.
Cranial Nerves: Cranial nerves II-XII intact.
Psych: Alert and oriented x3.

Assessment #1: F41.0 Panic disorder [episodic paroxysmal anxiety] without agoraphobia

Care Plan:

Comments	: Continue with psychologist for counselling.
Med Current	: Fluoxetine HCL 20 mg 1 po qd
Med New	: Fluoxetine HCL 20 mg 1 po qd
Follow Up	: . 4 wks

Seen by: Electronically signed by Mark L. Sarnov, M.D. on 05/17/2016 at 1:45 pm